be the responsibility of the principal of the organization and shall be submitted with each renewal (flat fee) payment;

3. duplicate certificates will be issued for a fee of not less than $5 per certificate.

4. water and wastewater operator certificates will be renewed on a two-year basis, with the fees remaining at the same annual rates as are currently in effect but collected every two years.

5. fees are to be paid in the form of a check or money order payable to the Committee of Certification, 6867 Bluebonnet Boulevard, Baton Rouge, LA 70810. Failure to attend the required training or failure to furnish the required information shall constitute grounds for refusal to renew the certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:507 (March 2002), repromulgated LR 28:843 (April 2002).

§7337. Reciprocity

A. Reciprocity shall be granted at the discretion of the committee of certification, without examination, to holders of comparable certificates issued by other states, territories, or possessions of the United States. The applicant for a certificate under the reciprocity clause must submit his application on an official application blank, obtainable from the administrator. The application must be accompanied by the appropriate fee. The applicant must submit a copy of his certificate or other proof, satisfactory to the committee of certification that he holds a certificate issued by a governmental agency of another state, territory or possession of the United States. Such certificates must have been received after passage of an examination at least equivalent to that given by the Louisiana committee of certification for the level of competency for which application is made.

B. The burden of proof to submit sufficient information for the committee of certification's consideration shall be upon the applicant. If, after receiving such an application, the committee of certification is satisfied that the applicant qualifies for a certificate, it may, at its discretion award him a certificate in the appropriate grade. A reciprocal certificate will not ordinarily be issued unless the applicant is employed, or has accepted employment, in a Louisiana water or wastewater facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:507 (March 2002), repromulgated LR 28:844 (April 2002).

§7339. Notification

A. Failure to receive any notices previously mentioned does not relieve the certificate holder or applicant from complying with the rules of the committee of certification. The burden is upon the certificate holder or applicant to provide the committee of certification with a current mailing address.

B. Any request for applications, training course approvals, reciprocity, etc., and/or questions on operator certification should be addressed to: Administrator, Operator Certification Program, DHH-OPH, 6867 Bluebonnet Boulevard, Baton Rouge, LA 70810.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1141-1151.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:507 (March 2002), repromulgated LR 28:844 (April 2002).

The amendment to Chapter XII of the Sanitary Code, State of Louisiana reads as follows:

Sanitary Code, State of Louisiana
Chapter XII (Water Supplies)

* * *

12:003-2: Plant Supervision and Control: All public water supplies shall be under the supervision and control of a duly certified operator as per requirements of the State Operator Certification Act, Act 538 of 1972, as amended (R.S. 40:1141-1151).

* * *

David W. Hood
Secretary

0204#038

RULE

Department of Insurance
Office of the Commissioner

Regulation 77 Medical Necessity Review Organizations
(LAC 37:XIII.Chapter 62)

In accordance with the provisions of R.S. 49:953 of the Administrative Procedure Act and R.S. 22:3090, the Department of Insurance has adopted the following Rule regarding standards for determining the necessity of medical care or services recommended by health care providers. This Rule is necessary to establish reasonable requirements for limiting covered services included in a policy or contract of insurance coverage that do not misrepresent the benefits, advantages, conditions, or terms of the policy issued, or to be issued, based on medical necessity determinations. This Rule establishes the statutory requirements for health insurance issuers who seek to make such limitations in products sold in this state and establish the standards for Medical Necessity Review Organizations seeking licensure under Title 22 of the Louisiana Revised Statutes of 1950.

Title 37
INSURANCE
Part XIII. Regulations

§6201. Purpose

A. The purpose of this regulation is to enforce the statutory requirements of Title 22 of the Louisiana Revised Statutes of 1950 that require health insurance issuers who seek to establish exception criteria or limitations on covered benefits that are otherwise offered and payable under a policy or certificate of coverage sold in this state, by requiring a medical necessity determination to be made by the health insurance issuer. The statutory requirements also apply to any health benefit plan that establishes exception criteria or limitations on covered benefits that are otherwise offered and payable under a non-federal government benefit plan. Additionally, the statute establishes a process for Medical Necessity Review Organizations to qualify for state licensure and Independent Review Organizations to become certified by the Department of Insurance. The statutory requirements establish the intent of the legislature to assure

licensed health insurance issuers and non-federal government benefit plans meet minimum quality standards and do not utilize any requirement that would act to impinge on the ability of insureds or government employees to receive appropriate medical advice and/or treatment from a health care professional. This Regulation has no effect on the statutory requirements of R.S. 22:657. Emergency medical conditions as defined in R.S. 22:657 shall be covered and payable as provided therein.

This regulation implements the statutory requirements of R.S. §§22:2021, and Chapter 7 of Title 22 of the Louisiana Revised Statutes regarding the use of medical necessity to limit stated benefits in a fully insured health policy or HMO certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:844 (April 2002).

§6203. Definitions

Adverse Determination a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and denied, reduced, or terminated by a reviewer based on medical necessity, appropriateness, health care setting, level of care, or effectiveness.

Ambulatory Review a review of health care services performed or provided in an outpatient setting.

Appropriate Medical Information all outpatient and inpatient medical records that are pertinent to the evaluation and management of the covered person and that permit the Medical Necessity Review Organization to determine compliance with the applicable clinical review criteria. In the review of coverage for particular services, these records may include, but are not necessarily limited to, one or more of the following portions of the covered person's medical records as they relate directly to the services under review for medical necessity: admission history and physical examination report, physician's orders, progress notes, nursing notes, operative reports, anesthesia records, hospital discharge summary, laboratory and pathology reports, radiology or other imaging reports, consultation reports, emergency room records, and medication records.

Authorized Representative a person to whom a covered person has given written consent to represent the covered person in an internal or external review of an adverse determination of medical necessity. *Authorized Representative* may include the covered person's treating provider, if the covered person appoints the provider as his authorized representative and the provider agrees and waives in writing, any right to payment from the covered person other than any applicable copayment or coinsurance amount. In the event that the service is determined not to be medically necessary by the MNRO/IRO, and the covered person or his authorized representative thereafter requests the services, nothing shall prohibit the provider from charging the provider's usual and customary charges for all MNRO/IRO determined non-medically necessary services provided when such requests are in writing.

Case Management a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

Certification or *Certify* a determination by a reviewer regarding coverage of an admission, continued stay, or other health care service for the purpose of determining medical necessity, appropriateness of the setting, or level of care.

Clinical Peer a physician or other health care professional who holds an unrestricted license in the same or an appropriate specialty that typically manages the medical condition, procedure, or treatment under review. Non-physician practitioners, including but not limited to nurses, speech and language therapists, occupational therapists, physical therapists, and clinical social workers, are not considered to be clinical peers and may not make adverse determinations of proposed actions of physicians (medical doctors shall be clinical peers of medical doctors, etc.).

Clinical Review Criteria the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a reviewer to determine the necessity and appropriateness of covered health care services.

Commissioner the commissioner of insurance.

Concurrent Review a review of medical necessity, appropriateness of care, or level of care conducted during a patient's stay or course of treatment.

Covered Benefits or *Benefits* those health care services to which a covered person is entitled under the terms of a health benefit plan.

Covered Person a policyholder, subscriber, enrollee, or other individual covered under a policy of health insurance or HMO subscriber agreement.

Discharge Planning the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

Disclose to release, transfer, or otherwise divulge protected health information to any individual, entity, or person other than the individual who is the subject of the protected health information.

Emergency Medical Condition a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. placing the health of the individual in serious jeopardy;
2. with respect to a pregnant woman, placing the health of the woman or her unborn child in serious jeopardy;
3. serious impairment to bodily function; or
4. serious dysfunction of any bodily organ or part.

Entity an individual, person, corporation, partnership, association, joint venture, joint stock company, trust, unincorporated organization, any similar entity, agent, or contractor, or any combination of the foregoing.

External Review Organization an independent review organization that conducts independent external reviews of adverse determinations and final adverse determinations and whose accreditation or certification has been reviewed and approved by the Department of Insurance.

Facility an institution providing health care services or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing facilities, inpatient hospice facilities, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.

Final Adverse Determination an adverse determination that has been upheld by a reviewer at the completion of the medical necessity review organization's internal review process as set forth in this Chapter.

Health Benefit Plan group and individual health insurance coverage, coverage provided under a group health plan, or coverage provided by a nonfederal governmental plan, as those terms are defined in R.S. 22:250.1. *Health Benefit Plan* shall not include a plan providing coverage for excepted benefits as defined in R.S. 22:250.1(3).

Health Care Professional a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law.

Health Care Provider or *Provider* a health care professional, the attending, ordering, or treating physician, or a facility.

Health Care Services services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

Health Information information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to any of the following:

1. the past, present, or future physical, mental, or behavioral health or condition of a covered person or a member of the covered person's family;
2. the provision of health care services to a covered person; or
3. payment for the provision of health care services to a covered person.

Health Insurance Coverage benefits consisting of medical care provided or arranged for directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer.

Health Insurance Issuer an insurance company, including a health maintenance organization, as defined and licensed pursuant to Part XII of Chapter 2 of this Title, unless preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974.

Medical Necessity Review Organization or *MNRO* a health insurance issuer or other entity licensed or authorized pursuant to this Chapter to make medical necessity determinations for purposes other than the diagnosis and treatment of a medical condition.

Prospective Review a review conducted prior to an admission or a course of treatment.

Protected Health Information health information that either identifies a covered person who is the subject of the information or with respect to which there is a reasonable basis to believe that the information could be used to identify a covered person.

Retrospective Review a review of medical necessity conducted after services have been provided to a patient, but shall not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

Second Opinion an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:845 (April 2002).

§6205. Authorization or Licensure as an MNRO

A. No health insurance issuer or health benefit plan, as defined in this chapter, shall act as an MNRO for the purpose of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar medical determinations unless authorized to act as an MNRO by the commissioner as provided in this Chapter. Benefits covered under a health benefit plan sold or in effect in this state on or after January 1, 2001 shall be limited, excluded, or excepted from coverage under any medical necessity determination requirement, appropriateness of care determination, level of care needed, or any other similar determination only when such determination is made by an authorized or licensed MNRO as provided in this Chapter.

B. No entity acting on behalf of or as the agent of a health insurance issuer may act as an MNRO for the purpose of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar determinations unless licensed as an MNRO by the commissioner as provided in this Chapter.

C. Any other entity may apply for and be issued a license under this Chapter to act as an MNRO for the purposes of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar determinations on behalf of a health benefit plan.

D. Any entity licensed or authorized as an MNRO shall be exempt from the requirements of R.S. 40:2721 through 2736. The licensure, authorization, or certification of any entity as an MNRO or independent or external review organization shall be effective beginning on the date of first application for all entities who receive formal written authorization, licensure, or certification by the Commissioner of Insurance. This provision shall remain in effect until December 31, 2001. Any application filed after December 31, 2001 shall become effective upon final approval by the Department of Insurance and not upon date of first application. Therefore any application submitted and filed after December 31, 2001, the licensure, authorization or certification of an entity as an MNRO or independent or external review organization shall be effective upon the date final approval is granted by the Commissioner of Insurance.

E. An integrated health care network or other entity contracting with a health insurance issuer for provision of

covered services under a risk sharing arrangement, shall be allowed to make initial adverse medical necessity determinations provided the health insurance issuer remains responsible for provision of internal and external review requirements and has submitted the information required under subsection B.5 of section 6207 for review and approval. In such instances, a covered person's request for an internal or external appeal of an adverse determination shall not require concurrence by a provider reimbursed under a risk sharing arrangement with the health insurance issuer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:846 (April 2002).

§6207. Procedure for Application to act as an MNRO

A. Any applicant for licensure other than a health insurance issuer shall submit an application to the commissioner and pay an initial licensure fee as specified in §6211.D. The application shall be on a form and accompanied by any supporting documentation required by the commissioner and shall be signed and verified by the applicant. The information required by the application shall include:

1. the name of the entity operating as an MNRO and any trade or business names used by that entity in connection with making medical necessity determinations;

2. the names and addresses of every officer and director of the entity operating as an MNRO, as well as the name and address of the corporate officer designated by the MNRO as the corporate representative to receive, review, and resolve all grievances addressed to the MNRO;

3. the name and address of every person owning, directly or indirectly, five percent or more of the entity operating as an MNRO;

4. the exact street and mailing address of the principal place of business where the MNRO will operate and conduct medical necessity review determinations;

5. a general description of the operation of the MNRO, which includes a statement that the MNRO does not engage in the practice of medicine or acts to impinge or encumber the independent medical judgment of treating physicians or health care providers;

6. a description of the MNRO's program that evidences it meets the requirements of this Chapter for making medical necessity determinations and resolving disputes on an internal and external basis. (Such program description shall evidence compliance with requirements of §6213 of this Chapter);

7. a sample copy of any contract, absent fees charged, with a health insurance issuer, nonfederal government health benefit plan, or other group health plan for making determinations of medical necessity;

8. for each individual that will be designated to make adverse medical necessity determinations pursuant to this Chapter:

a. a description of the types of determinations that will be made by the individual and the type of license that will be required to support such determinations; and

b. a written policy statement that the individual shall have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character;

c. a written policy statement that the individual will be required to attest that no adverse determination will be made regarding any medical procedure or service outside the scope of such individual's expertise.

B. A health insurance issuer holding a valid certificate of authority to operate in this state may be authorized to act as an MNRO under the requirements of this Chapter following submission to the commissioner of appropriate documentation for review and approval that shall include, but need not be limited, to the following:

1. the exact street and mailing address of the principal place of business where the MNRO will operate and conduct medical necessity review determinations;

2. a general description of the operation of the MNRO which includes a statement that the MNRO does not engage in the practice of medicine or act to impinge upon or encumber the independent medical judgment of treating physicians or health care providers;

3. a description of the MNRO's program that evidences it meets the requirements of this Chapter for making medical necessity determinations and resolving disputes on an internal and external basis. (Such program description shall evidence compliance with requirements of Section 6213 of this Chapter);

4. a sample copy of any contract, absent fees charged, with another health insurance issuer for making determinations of medical necessity;

5. for each individual that will be designated to make adverse medical necessity determinations pursuant to this Chapter:

a. a description of the types of determinations that will be made by the individual and the type of license that will be required to support such determinations;

b. a written policy statement that the individual shall have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character; and

c. a written policy statement that the individual will be required to attest that no adverse determination will be made regarding any medical procedure or service outside the scope of such individual's expertise.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and, 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:847 (April 2002).

§6211. Expiration and Renewal of License for Entities other than Health Insurance Issuers

A. Licensure pursuant to this Chapter shall expire two years from the date approved by the commissioner unless the license is renewed for a two-year term as provided in this Section.

B. Before a license expires, it may be renewed for an additional two-year term if the applicant pays a renewal fee as provided in this Section and submits to the commissioner a renewal application on the form that the commissioner requires.

C. The renewal application required by the commissioner shall include, but need not be limited to, the information required for an initial application.

D. The fee for initial licensure and the fee for renewal of licensure shall each be $1,500.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014 and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:848 (April 2002).

§6213. Scope and Content of Medical Necessity Determination Process

A. An MNRO shall implement a written medical necessity determination program that describes all review activities performed for one or more health benefit plans. The program shall include the following:

1. the methodology utilized to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services;

2. data sources and clinical review of criteria used in decision-making. The appropriateness of clinical review criteria shall be fully documented;

3. the process for conducting appeals of adverse determinations including informal reconsiderations;

4. mechanisms to ensure consistent application of review criteria and compatible decisions;

5. data collection processes and analytical methods used in assessing utilization of health care services;

6. provisions for assuring confidentiality of clinical and proprietary information;

7. the organizational structure, including any review panel or committee, quality assurance committee, or other committee that periodically accesses health care review activities and reports to the health benefit plan;

8. the medical director's responsibilities for day-to-day program management;

9. any quality management program utilized by the MNRO.

B. An MNRO shall file with the commissioner an annual summary report of its review program activities that includes a description of any substantive changes that have been implemented since the last annual report.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:848 (April 2002).

§6215. Medical Necessity Review Organization Operational Requirements

A. An MNRO shall use documented clinical review criteria that are based on sound clinical evidence. Such criteria shall be evaluated at least annually and updated if necessary to assure ongoing efficacy. An MNRO may develop its own clinical review criteria or it may purchase, license or contract for clinical review criteria from qualified vendors. An MNRO shall make available its clinical review criteria upon request to the commissioner who shall be authorized to request affirmation of such criteria from other appropriate state regulatory agencies.

B. An MNRO shall have a medical director who shall be a duly licensed physician. The medical director shall administer the program and oversee all adverse review decisions. Adverse determinations shall be made only by a duly licensed physician or clinical peer. An adverse determination made by an MNRO in the second level review shall become final only when a clinical peer has evaluated and concurred with such adverse determination.

C. An MNRO shall issue determination decisions in a timely manner pursuant to the requirements of this Chapter. At the time of the request for review, an MNRO shall notify the requestor of all documentation required to make a medical review determination. The requestor may include the covered person, an authorized representative, or a provider. In the event that the MNRO determines that additional information is required, it shall notify the requestor by telephone, within one workday of such determination, to request any additional appropriate medical information required. An MNRO shall obtain all information required to make a medical necessity determination, including pertinent clinical information, and shall have a process to ensure that qualified health care professionals performing medical necessity determinations apply clinical review criteria consistently.

D. At least annually, an MNRO shall routinely assess the effectiveness and efficiency of its medical necessity determination program and report any deficiencies or changes to the commissioner. Deficiencies shall include complaint investigations by the department or grievances filed with the MNRO that prompted the MNRO to change procedures or protocols.

E. An MNRO's data systems shall be sufficient to support review program activities and to generate management reports to enable the health insurance issuer or other contractor to monitor its activities.

F. Health insurance issuers who delegate any medical necessity determination functions to an MNRO shall be responsible for oversight, which shall include, but not be limited to, the following:

1. a written description of the MNRO's activities and responsibilities, including reporting requirements;

2. evidence of formal approval of the medical necessity determination program by the health insurance issuer;

3. a process by which the health insurance issuer monitors or evaluates the performance of the MNRO.

G. Health insurance issuers who perform medical necessity determinations shall coordinate such program with

other medical management activities conducted by the health insurance issuer, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction, and risk management.

H. An MNRO shall provide health care providers with access to its review staff by a toll-free number that is operational for any period of time that an authorization, certification, or approval of coverage is required.

I. When conducting medical necessity determinations, the MNRO shall request only the information necessary to certify an admission to a facility, procedure or treatment, length of stay, frequency, level of care or duration of health care services.

J. Compensation to individuals participating in a medical necessity determination program shall not contain incentives, direct or indirect, for those individuals to make inappropriate or adverse review determinations. Compensation to any such individuals shall not be based, directly or indirectly, on the quantity or type of adverse determinations rendered.

K. An adverse determination shall not be based on the outcome of care or clinical information not available at the time the certification was made, regardless of whether the covered person or provider assumes potential liability for the cost of such care while awaiting a coverage determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:848 (April 2002).

§6217. Procedures for Making Medical Necessity Determinations

A. An MNRO shall maintain written procedures for making determinations and for notifying covered persons and providers and other authorized representatives acting on behalf of covered persons of its decisions.

B.1. In no less than eighty percent of initial determinations, an MNRO shall make the determination within two working days of obtaining any appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. In no instance shall any determination of medical necessity be made later than thirty days from receipt of the request unless the patient's physician or other authorized representative has agreed to an extension.

2. In the case of a determination to certify a nonemergency admission, procedure, or service, the MNRO shall notify the provider rendering the service within one work day of making the initial certification and shall provide documented confirmation of such notification to the provider within two working days of making the initial certification.

3. In the case of an adverse determination of a nonemergency admission, the MNRO shall notify the provider rendering the service within one workday of making the adverse determination and shall provide documented confirmation of the notification to the provider within two working days of making the adverse determination.

C.1. For concurrent review determinations of medical necessity, an MNRO shall make such determinations within one working day of obtaining the results of appropriate medical information that may be required.

2. In the case of a determination to certify an extended stay or additional services, the MNRO shall notify the provider rendering the service within one working day of making the certification and shall provide documented confirmation to the provider within two working days of the authorization. Such documented notification shall include the number of intended days or next review date and the new total number of days or services approved.

3. In the case of an adverse determination, the MNRO shall notify the provider rendering the service within one working day of making the adverse determination and shall provide documented notification to the provider within one workday of such notification. The service shall be authorized and payable by the health insurance issuer without liability, subject to the provisions of the policy or subscriber agreement, until the provider has been notified in writing of the adverse determination. The covered person shall not be liable for the cost of any services delivered following documented notification to the provider unless notified of such liability in advance.

D.1. For retrospective review determinations, the MNRO shall make the determination within 30 working days of obtaining the results of any appropriate medical information that may be required, but in no instance later than 180 days from the date of service. The MNRO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon prior approval, unless the approval was based upon a material omission or misrepresentation about the covered person's health condition made by the provider or unless the coverage was duly canceled for fraud, misrepresentation, or nonpayment of premiums.

2. In the case of an adverse determination, the MNRO shall notify in writing the provider rendering the service and the covered person within five working days of making the adverse determination.

E. A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. An MNRO shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who follows the procedures.

F. An MNRO shall have written procedures listing the health or appropriate medical information required from a covered person or health care provider in order to make a medical necessity determination. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall also outline the process to be followed in the event that the MNRO determines the need for additional information not initially requested.

G An MNRO shall have written procedures to address the failure or inability of a provider or a covered person to provide all necessary information for review. In cases where

the provider or a covered person will not release necessary information, the MNRO may deny certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:849 (April 2002).

§6219. Informal Reconsideration

A. In a case involving an initial determination or a concurrent review determination, an MNRO shall give the provider rendering the service an opportunity to request, on behalf of the covered person, an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination. Allowing a 10-day period following the date of the adverse determination for requesting an informal reconsideration shall be considered reasonable.

B. The informal reconsideration shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the MNRO's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one working day.

C. If the informal reconsideration process does not resolve the differences of opinion, the adverse determination may be appealed by the covered person or the provider on behalf of the covered person. Informal reconsideration shall not be a prerequisite to a standard appeal or an expedited appeal of an adverse determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:850 (April 2002).

§6221. Appeals of Adverse Determinations; Standard Appeals

A. An MNRO shall establish written procedures for a standard appeal of an adverse determination, which may also be known as a first level internal appeal. Such procedures shall be available to the covered person and to the provider acting on behalf of the covered person. Such procedures shall provide for an appropriate review panel for each appeal that includes health care professionals who have appropriate expertise. Allowing a 60-day period following the date of the adverse determination for requesting a standard appeal shall be considered reasonable.

B. For standard appeals, a duly licensed physician shall be required to concur with any adverse determination made by the review panel.

C. The MNRO shall notify in writing both the covered person and any provider given notice of the adverse determination, of the decision within thirty working days following the request for an appeal, unless the covered person or authorized representative and the MNRO mutually agree that a further extension of the time limit would be in the best interest of the covered person. The written decision shall contain the following:

1. the title and qualifying credentials of the physician affirming the adverse determination;

2. a statement of the reason for the covered person's request for an appeal;

3. an explanation of the reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the MNRO's position;

4. if applicable, a statement including the following:

a. a description of the process to obtain a second level review of a decision;

b. the written procedures governing a second level review, including any required time frame for review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:850 (April 2002).

§6223. Second Level Review

A. An MNRO shall establish a second level review process to give covered persons who are dissatisfied with the first level review decision the option to request a review at which the covered person has the right to appear in person before authorized representatives of the MNRO. An MNRO shall provide covered persons with adequate notice of this option, as described in Section 6221.C. Allowing a 30-day period following the date of the notice of an adverse standard appeal decision shall be considered reasonable.

B. An MNRO shall conduct a second level review for each appeal. Appeals shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer shall not have been involved in the initial adverse determination. A majority of any review panel used shall be comprised of persons who were not previously involved in the appeal. However, a person who was previously involved with the appeal may be a member of the panel or appear before the panel to present information or answer questions. The panel shall have the legal authority to bind the MNRO and the health insurance issuer to the panel's decision.

C. An MNRO shall ensure that a majority of the persons reviewing a second level appeal are health care professionals who have appropriate expertise. An MNRO shall issue a copy of the written decision to a provider who submits an appeal on behalf of a covered person. In cases where there has been a denial of service, the reviewing health care professional shall not have a material financial incentive or interest in the outcome of the review.

D. The procedures for conducting a second level review shall include the following.

1. The review panel shall schedule and hold a review meeting within 45 working days of receivinga request from a covered person for a second level review. The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person. In cases where a face-to-face meeting is not practical for geographic reasons, an MNRO shall offer the covered person and any provider given a notice of adverse determination the opportunity to communicate with the review panel, at the MNRO's expense, by conference call, video conferencing, or other appropriate technology. The covered person shall be notified of the time and place of the review meeting in writing at least 15 working days in

advance of the review date; such notice shall also advise the covered person of his rights as specified in Paragraph three of this Subsection. The MNRO shall not unreasonably deny a request for postponement of a review meeting made by a covered person.

2. Upon the request of a covered person, an MNRO shall provide to the covered person all relevant information that is not confidential or privileged.

3. A covered person shall have the right to the following:

a. attend the second level review;

b. present his case to the review panel;

c. submit supporting material and provide testimony in person or in writing or affidavit both before and at the review meeting;

d. ask questions of any representative of the MNRO.

4. The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.

5. For second level appeals, a duly licensed and appropriate clinical peer shall be required to concur with any adverse determination made by the review panel.

6. The MNRO shall issue a written decision to the covered person within five working days of completing the review meeting. The decision shall include the following:

a. the title and qualifying credentials of the appropriate clinical peer affirming an adverse determination;

b. a statement of the nature of the appeal and all pertinent facts;

c. the rationale for the decision;

d. reference to evidence or documentation used in making that decision;

e. the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination;

f. notice of the covered person's right to an external review, including the following:

i. a description of the process to obtain an external review of a decision;

ii. the written procedures governing an external review, including any required time frame for review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:850 (April 2002).

§6225. Request for External Review

A. Each health benefit plan shall provide an independent review process to examine the plan's coverage decisions based on medical necessity. A covered person, with the concurrence of the treating health care provider, may make a request for an external review of a second level appeal adverse determination.

B. Except as provided in this Subsection, an MNRO shall not be required to grant a request for an external review until the second level appeal process as set forth in this Chapter has been exhausted. A request for external review of an adverse determination may be made before the covered person has exhausted the MNRO's appeal, if any of the following circumstances apply.

1. The covered person has an emergency medical condition, as defined in this Chapter.

2. The MNRO agrees to waive the requirements for the first level appeal, the second level appeal, or both.

C. If the requirement to exhaust the MNRO's appeal procedures is waived under Paragraph B.1 of this Section, the covered person's treating health care provider may request an expedited external review. If the requirement to exhaust the MNRO's appeal procedures is waived under Paragraph B.2 of this Section, a standard external review shall be performed.

D. Nothing in this Section shall prevent an MNRO from establishing an appeal process, approved by the commissioner, that provides persons who are dissatisfied with the first level review decision an external review in lieu of requiring a second level review prior to requesting such external review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 22:3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:851 (April 2002).

§6227. Standard External Review

A. Within sixty days after the date of receipt of a notice of a second level appeal adverse determination, thecovered person whose medical care was the subject of such determination may, with the concurrence of the treating health care provider, file a request for an external review with the MNRO. Within seven days after the date of receipt of the request for an external review, the MNRO shall provide the documents and any information used in making the second level appeal adverse determination to its designated independent review organization. The independent review organization shall review all of the information and documents received and any other information submitted in writing by the covered person or the covered person's health care provider. The independent review organization may consider the following in reaching a decision or making a recommendation:

1. the covered person's pertinent medical records;

2. the treating health care professional's recommendation;

3. consulting reports from appropriate health care professionals and other documents submitted by the MNRO, covered person, or the covered person's treating provider;

4. any applicable generally accepted practice guidelines, including but not limited to those developed by the federal government or national or professional medical societies, boards, and associations;

5. any applicable clinical review criteria developed exclusively and used by MNRO that are within the appropriate standard for care, provided such criteria were not the sole basis for the decision or recommendation unless the criteria had been reviewed and certified by the appropriate licensing board of this state.

B. The independent review organization shall provide notice of its recommendation to the MNRO, the covered person or his authorized representative and the covered person's health care provider within 30 days after the date of receipt of the second level determination information subject

to an external review, unless a longer period is agreed to by all parties.

AUTHORITY NOTE: Promulgated in accordance with La. R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: La. R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:851 (April 2002).

§6229. Expedited Appeals

A. An MNRO shall establish written procedures for the expedited appeal of an adverse determination involving a situation where the time frame of the standard appeal would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. An expedited appeal shall be available to and may be initiated by the covered person, with the consent of the treating health care professional, or the provider acting on behalf of the covered person.

B. Expedited appeals shall be evaluated by an appropriate clinical peer or peers in the same or a similar specialty as would typically manage the case under review. The clinical peer or peers shall not have been involved in the initial adverse determination.

C. An MNRO shall provide an expedited appeal to any request concerning an admission, availability of care, continued stay, or health care service for a covered person who has received emergency services but has not been discharged from a facility. Such emergency services may include services delivered in the emergency room, during observation, or other setting that resulted in direct admission to a facility.

D. In an expedited appeal, all necessary information, including the MNRO's decision, shall be transmitted between the MNRO and the covered person, or his authorized representative, or the provider acting on behalf of the covered person by telephone, telefacsimile, or any other available expeditious method.

E. In an expedited appeal, an MNRO shall make a decision and notify the covered person or the provider acting on behalf of the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the appeal is commenced. If the expedited appeal is a concurrent review determination, the service shall be authorized and payable, subject to the provisions of the policy or subscriber agreement, until the provider has been notified of the determination in writing. The covered person shall not be liable for the cost of any services delivered following documented notification to the provider until documented notification of such liability is provided to the covered person.

F. An MNRO shall provide written confirmation of its decision concerning an expedited appeal within two working days of providing notification of that decision if the initial notification was not in writing. The written decision shall contain the information specified in R.S. 22:3079.C(1) through (3).

G An MNRO shall provide reasonable access, within a period of time not to exceed one workday, to a clinical peer who can perform the expedited appeal.

H In any case where the expedited appeal process does not resolve a difference of opinion between the MNRO and the covered person or the provider acting on behalf of the covered person, such provider may request a second level appeal of the adverse determination.

I. An MNRO shall not provide an expedited appeal for retrospective adverse determinations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:852 (April 2002).

§6231. Expedited External Review of Urgent Care Requests

A. At the time that a covered person receives an adverse determination involving an emergency medical condition of the covered person being treated in the emergency room, during hospital observation, or as a hospital inpatient, the covered person's health care provider may request an expedited external review. Approval of such requests shall not unreasonably be withheld.

B. For emergency medical conditions, the MNRO shall provide or transmit all necessary documents and information used in making the adverse determination to the independent review organization by telephone, telefacsimile, or any other available expeditious method.

C. In addition to the documents and information provided or transmitted, the independent review organization may consider the following in reaching a decision or making a recommendation:

1. the covered person's pertinent medical records;

2. the treating health care professional's recommendation;

3. consulting reports from appropriate health care professionals and other documents submitted by the MNRO, the covered person, or the covered person's treating provider;

4. any applicable generally accepted practice guidelines, including but not limited to those developed by the federal government or national or professional medical societies, boards, and associations.;

5. Any applicable clinical review criteria developed exclusively and used by the MNRO that are within the appropriate standard for care, provided such criteria were not the sole basis for the decision or recommendation, unless the criteria had been reviewed and certified by the appropriate state licensing board of this state.

D. Within 72 hours after receiving appropriate medical information for an expedited external review, the independent review organization shall do the following:

1. make a decision to uphold or reverse the adverse determination;

2. notify the covered person, the MNRO, and the covered person's health care provider of the decision. Such notice shall include the principal reason or reasons for the decision and references to the evidence or documentation considered in making the decision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:852 (April 2002).

§6233. Binding Nature of External Review Decisions

A. Coverage for the services required under this Chapter shall be provided subject to the terms and conditions

generally applicable to benefits under the evidence of coverage under a health insurance policy or HMO subscriber agreement. Nothing in this Chapter shall be construed to require payment for services that are not otherwise covered pursuant to the evidence of coverage under the health insurance policy or HMO subscriber agreement or otherwise required under any applicable state or federal law.

B. An external review decision made pursuant to this Chapter shall be binding on the MNRO and on any health insurance issuer or health benefit plan that utilizes the MNRO for making medical necessity determinations. No entity shall hold itself out to the public as following the standards of a licensed or authorized MNRO that does not adhere to all requirements of this Chapter including the binding nature of external review decisions.

C. An external review decision shall be binding on the covered person for purposes of determining coverage under a health benefit plan that requires a determination of medical necessity for a medical service to be covered.

D. A covered person or his representatives, heirs, assigns, or health care providers shall have a cause of action for benefits or damages against an MNRO, health insurance issuer, health benefit plan, or independent review organization for any action involving or resulting from a decision made pursuant to this Chapter if the determination or opinion was rendered in bad faith or involved negligence, gross negligence, or intentional misrepresentation of factual information about the covered person's medical condition. Causes of action for benefits or damages for actions involving or resulting from a decision made pursuant to this Chapter shall be limited to the party acting in bad faith, or involved in negligence, gross negligence or intentional misrepresentation of factual information about the covered person's medical condition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:852 (April 2002).

§6235. Minimum Qualifications for Independent Review Organizations

A. The licensure, authorization, or certification of any entity as an MNRO or independent or external review organization shall be effective beginning on the date of first application for all entities who receive formal written authorization, licensure, or certification by the Commissioner of Insurance. This provision shall remain in effect until December 31, 2001. Any application filed after December 31, 2001 shall become effective upon final approval by the Department of Insurance and not upon date of first application. Therefore any application submitted and filed after December 31, 2001, the licensure, authorization or certification of an entity as an MNRO or independent or external review organization shall be effective upon the date final approval is granted by the Commissioner of Insurance. To qualify to conduct external reviews for an MNRO, an independent review organization shall meet the following minimum qualifications:

1. develop written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process that include, at a minimum, the following:

a. procedures to ensure that external reviews are conducted within the specified time frames and that required notices are provided in a timely manner;

b. procedures to ensure the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases;

c. procedures to ensure the confidentiality of medical and treatment records and clinical review criteria;

d. procedures to ensure that any individual employed by or under contract with the independent review organization adheres to the requirements of this Chapter;

2. establish a quality assurance program;

3. establish a toll-free telephone service to receive information related to external reviews on a twenty-four-hour-day, seven-day-a-week basis that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other than normal business hours.

B. Any clinical peer reviewer assigned by an independent review organization to conduct external reviews shall be a physician or other appropriate health care provider who meets the following minimum qualifications:

1. be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

2. be knowledgeable about the recommended health care service or treatment through actual clinical experience that may be based on either of the following:

a. the period of time spent actually treating patients with the same or similar medical condition of the covered person;

b. the period of time that has elapsed between the clinical experience and the present.

3. hold a nonrestricted license in a state of the United States and, in the case of a physician, hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review;

4. have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character.

C. In addition to the requirements of Subsection A of this Section, an independent review organization shall not own or control, be a subsidiary of, in any way be owned or controlled by, or exercise control with a health insurance issuer, health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers.

D. In addition to the other requirements of this Section, in order to qualify to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor the clinical peer reviewer assigned by the independent organization to conduct the external review shall have a material professional, familial, or financial interest with any of the following:

1. the MNRO that is the subject of the external review;

2. any officer, director, or management employee of the MNRO that is the subject of the external review;

3. the health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

4. the facility at which the recommended health care service or treatment would be provided;

5. the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review;

6. the covered person who is the subject of the external review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:853 (April 2002).

§6237. External Review Register

A. An MNRO shall maintain written records in the aggregate and by health insurance issuer and health benefit plan on all requests for external review for which an external review was conducted during a calendar year, hereinafter referred to as the "register". For each request for external review, the register shall contain, at a minimum, the following information:

1. a general description of the reason for the request for external review;

2. the date received;

3. the date of each review;

4. the resolution;

5. the date of resolution;

6. except as otherwise required by state or federal law, the name of the covered person for whom the request for external review was filed.

B. The register shall be maintained in a manner that is reasonably clear and accessible to the commissioner.

C. The register compiled for a calendar year shall be retained for the longer of three years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.

D. The MNRO shall submit to the commissioner, at least annually, a report in the format specified by the commissioner. The report shall include the following for each health insurance issuer and health benefit plan:

1. the total number of requests for external review;

2. the number of requests for external review resolved and their resolution;

3. a synopsis of actions being taken to correct problems identified.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:854 (April 2002).

§6239. Emergency Services

A. Emergency services shall not be limited to health care services rendered in a hospital emergency room.

B. When conducting medical necessity determinations for emergency services, an MNRO shall not disapprove emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of such services if a prudent lay person acting reasonably would have believed that an emergency medical condition existed. With respect to care obtained from a non-contracting provider within the service area of a managed care plan, an MNRO shall not disapprove emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of the services if a prudent lay person would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency or if a provision of federal, state, or local law requires the use of a specific provider.

C. If a participating provider or other authorized representative of a health insurance issuer or health benefit plan authorizes emergency services, the MNRO shall not subsequently retract its authorization after the emergency services have been provided or reduce payment for an item, treatment, or service furnished in reliance upon approval, unless the approval was based upon a material omission or misrepresentation about the covered person's health condition made by the provider of emergency services.

D. Coverage of emergency services shall be subject to state and federal laws as well as contract or policy provisions, including co-payments or coinsurance and deductibles.

E. For immediately required post-evaluation or post-stabilization services, an MNRO shall provide access to an authorized representative twenty-four hours a day, seven days a week, to facilitate review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:854 (April 2002).

§6241. Confidentiality Requirements

A. An MNRO shall annually provide written certification to the commissioner that its program for determining medical necessity complies with all applicable state and federal laws establishing confidentiality and reporting requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 22:2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statutes of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:854 (April 2002).

§6243. Severability

A. If any provision or item of this regulation, or the application thereof, is held invalid, such invalidity shall not affect other provisions, items, or applications of the regulation that can be given effect without the invalid provisions, item, or application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statute of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:854 (April 2002).

§6245. Effective Date

A. This regulation shall become effective upon final publication in the Louisiana Register.

AUTHORITY NOTE: Promulgated in accordance with R.S. 22:3, 2014; and 3090, to implement and enforce the following provisions: R.S. 22:2021 and Chapter 7 of Title 22 of the Revised Statute of 1950.

HISTORICAL NOTE: Promulgated by the Department of Insurance, Office of the Commissioner, LR 28:855 (April 2002).

J. Robert Wooley
Acting Commissioner

0204#049

RULE

Department of Public Safety and Corrections
Board of Private Investigator Examiners

Private Investigator Continuing Education
(LAC 46:LVII.518)

In accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and under the authority of R.S. 37:3505.B.(1), the Louisiana Department of Public Safety and Corrections, Louisiana State Board of Private Investigator Examiners, has amended Part LVII of Title 46, amending Chapter 5, Section 518, to require licensees to attend eight hours of continuing education every year (not every two years as the current law requires) and to further require renewal applications for each year to show compliance with this continuing education requirement.

This rule and regulation is an amendment to the initial rules and regulations promulgated by the Louisiana State Board of Private Investigator Examiners.

Title 46
PROFESSIONAL AND OCCUPATIONAL STANDARDS
Part LVII. Louisiana State Board of Private Investigator Examiners
Chapter 5. Application, Licensing, Training, Registration and Fees

§518. Continuing Education

A. Each licensed private investigator is required to complete a minimum of eight hours of approved investigative educational instruction within the one year period immediately prior to renewal in order to qualify for a renewal license.

B. Each licensed private investigator is required to complete and return the LSBPIE Continuing Educational Compliance form with the request for license renewal each year. The form shall be signed under penalty of perjury and shall include documentation of each hour of approved investigation educational instruction completed.

C. Any licensee who wishes to apply for an extension of time to complete educational instruction requirements must submit a letter request setting forth reasons for the extension request to the Executive Director of the LSBPIE 30 days prior to license renewal. The Training Committee shall rule on each request. If an extension is granted, the investigator shall be granted 30 days to complete the required hours. Hours completed during a 30 day extension shall only apply to the previous year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3505.B.(1).

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Board of Private Investigator Examiners, LR 22:371 (May 1996), amended LR 27:1016 (July 2001), LR 28:855 (April 2002).

Charlene Mora
Chairman

0204#017

RULE

Department of Public Safety and Corrections
Gaming Control Board

Electronic Cards, General Credit Provisions
(LAC 42:III.201)

The Louisiana Gaming Control Board has adopted LAC 42:III.201 in accordance with R.S. 27:15 and 24, and the Administrative Procedure Act, R.S. 49:950 et seq.

Title 42
LOUISIANA GAMING
Part III. Gaming Control Board
Chapter 2. Electronic Cards

§201. General Credit Provisions

A. No Casino Operator, Casino Manager or licensee, either directly or through any bank, financial institution, credit card company or similar entity, shall issue electronic cards or smart cards that have the capability of allowing patrons to access any line of credit or account, debit an account, or obtain credit through a credit agreement or otherwise allow any patron to incur debt in any manner not provided in the respective Casino Operator's, Casino Manager's or licensee's internal controls as approved by the division.

B. All electronic cards or smart cards issued by the Casino Operator, Casino Manager or any licensee for the purpose of wagering shall be prepaid with a fixed dollar amount that shall not be susceptible of being increased by patrons without purchasing additional value in a manner consistent with the respective Casino Operator's, Casino Manager's or licensee's internal controls as approved by the division.

C. Electronic cards or smart cards issued by the Casino Operator, Casino Manager or any licensee shall be used only for wagering at the respective Casino Operator's, or licensee's property.

AUTHORITY NOTE: Promulgated in accordance with R.S. 27:15 and 24.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Gaming Control Board, LR 28:855 (April 2002).

Hillary J. Crain
Chairman

0204#011